NEWTOWN PUBLIC SCHOOLS
INSURANCE CHANGE FORM
2023-2024

Please return to Denise Hornyak in the Business Office

A. EMPLOYEE INFORMATION

Last Name	First Name		Middle Initial
Street Address	**Town/City**	**State**	**Zip Code**

B. ANTHEM MEDICAL COVERAGE CHANGES

☐ I am canceling dependent(s): _____

C. DENTAL COVERAGE CHANGES

☐ I am canceling dependent(s): _____

D. VISION COVERAGE CHANGES

☐ I am canceling dependent(s): _____

_____

SIGNATURE REQUIRED